HIV/AIDS Education Project

Iowa HIV

TRAINING & EDUCATION NEEDS ASSESSMENT:

1999-2000 Survey for Middle and High Schools

Prepared for:
Iowa Department of Education
Bureau of Instructional Services

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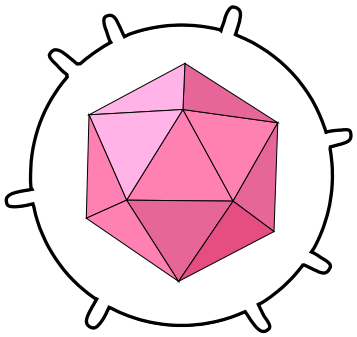

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Iowa HIV Training and Education Needs Assessment:

1999-2000 Survey for Middle and High Schools

A *needs assessment* has been defined as "the process of determining, analyzing, and prioritizing needs and, in turn, identifying and implementing solution strategies to resolve high-priority needs" (Altschuld & Witkin, 2000). In 1999 we began work on a needs assessment in the area of HIV training and education for middle and high schools. This utilized results from three instruments: (1) the 1997 Iowa Youth Risk Behavior Survey (YRBS), (2) the 1998 Iowa School Health Education Profile (SHEP), and (3) an instrument developed to assess needs not measured by either the YRBS or the SHEP. In this report we focus on determining and analyzing HIV training needs. The processes of prioritizing these needs and identifying/implementing solution strategies to resolve those of high priority will addressed at a later time. Moreover, a needs assessment for HIV training and education in elementary schools is to be conducted in 2000-2001. (We have already met with elementary health educators and collaborative services program staff working with student health issues to develop an instrument for this assessment.)

Preliminary Needs Assessment: 1997 Iowa YRBS and 1998 Iowa SHEP

The questions relating to HIV training and/or education in the 1997 Youth Risk Behavior Survey (YRBS) and the 1998 School Health Education Profile (SHEP) provide a basis for thinking about HIV needs for Iowa's middle and high schools in 1999-2000. The YRBS may be viewed as a needs assessment from the standpoint of high school students in Iowa, while the SHEP may be considered a needs assessment from the perspective of the middle, junior high, and senior high school principals and lead health education teachers. These surveys were not specifically designed to be *HIV training/education needs assessments*, however, and therefore will provide somewhat limited data in that regard.

It should be noted that both of these surveys produced "weighted" results. Thus, the YRBS data generalize to all Iowa high school students, while the SHEP data generalize to all middle, junior high, and senior high school principals and lead health education teachers in the state. Thus, the quality of the data from these surveys is quite high. These results are briefly summarized below.

> [Note: The 1999 Iowa YRBS was conducted for (i) regular (traditional) and (ii) alternative high schools. However, neither of these sets of results were weighted, since the response rates were insufficient. Thus, the 1997 Iowa YRBS results were used since they generalize to all Iowa high school students in that year.]

1. 1997 Iowa YRBS Results Relating to HIV Training/Education

The following results from the 1997 Iowa YRBS relate to needs regarding HIV education among senior high school students in the state:

- About 92% of students had been taught about AIDS or HIV infection in school.
- About 56% of students indicated they had talked about AIDS or HIV with parents or other adults in their family. The percentage

who talked about AIDS or HIV with parents or adults was higher for female students than for males.

- About 43 out of 100 students indicated they had sexual intercourse at some time in their lives. Percentagewise, more students in Grades 10-12 indicated that they had engaged in sexual intercourse than those in the 9th grade; more students in Grades 11 and 12 so indicated than those in 9th and 10th grade.
- About 4% of students indicated they had sexual intercourse for the first time prior to age 13. Percentagewise, more males than females indicated they had sexual intercourse before age 13.
- About 13% of students indicated they had sexual intercourse with four or more people during their lives. Percentagewise, more students in Grades 11 and 12 had intercourse with four or more people than those in Grades 9 and 10, respectively.
- About one-third of students indicated they had sexual intercourse during the past three months. Percentagewise, fewer 9th grade students than those in the higher grades indicated they had sexual intercourse during the past three months; more 12th grade students than those in Grade 10 so indicated.

Thus, according to the students themselves most had received some HIV/AIDS education in school, over half were communicating with their parents or adults about HIV/AIDS, but many were involved in risky behaviors that could lead to HIV infection and/or AIDS.

2. 1998 Iowa SHEP Results Relating to HIV Training/Education

The following results from the 1998 Iowa SHEP relate to HIV training and/or education among principals and teachers in middle, junior high, and senior high schools in the state:

- A little over two-thirds (68%) of the schools have a written policy on students/staff with HIV or AIDS. Most frequently mentioned HIV/AIDS issues addressed in these policies included worksite safety, maintaining confidentiality, implementing the HIV policy, protecting HIV-infected students/staff from discrimination, and attendance of students with HIV infection/AIDS.
- It was estimated that 92% of schools in Iowa with grades 6-12 taught HIV infection/AIDS in 1998 as part of required health education courses.[1]
- HIV/AIDS education is primarily taught in 7th and 8th grades (middle school), 7th - 10th grades (junior/senior high), and 9th and 10th grades (senior high). Less than 50% indicated that HIV/AIDS was taught in Grade 12.

[1] Note that the percentage of schools teaching HIV/AIDS as part of required health education courses in 1998 according to the SHEP is *exactly* equal to the percentage of students indicating they had received HIV/AIDS education in 1997 according to the YRBS. This may be taken as evidence of (1) accuracy of the percentage teaching (taking) HIV/AIDS classes and (2) stability in teaching (taking) HIV/AIDS classes over this two year period.

- How HIV is and is not transmitted, how HIV affects the immune system, knowledge about (a) needle sharing and (b) sexual behavior and HIV transmission, reasons for choosing sexual abstinence, and the influence of alcohol and other drugs on HIV infection risk behaviors were topics most frequently mentioned as being taught as part of HIV prevention/AIDS education.
- Most frequently selected types of inservice training included cardiopulmonary resuscitation (CPR), physical activity/fitness (in middle school), sexual harassment (in middle and junior/senior high school), and *HIV prevention (in senior high school)*. Suicide prevention was the most frequently selected topic on which lead health education teachers would like to receive inservice training.
- Lead health education teachers reported that sending letters/newsletters to parents was the most frequently used strategy for involving parents in required health education and *HIV prevention/AIDS education*. Most principals reported positive feedback from parents.

According to principals and lead health education teachers in 1998, HIV/AIDS is being taught in most schools as part of required health courses (more in lower grades, less in 12th grade), most schools had written policies on students/staff with HIV or AIDS, how HIV is and is not transmitted and reasons for choosing sexual abstinence were frequently selected as topics being taught, HIV prevention training was provided (in senior high schools), and parents were involved in required health education (including HIV prevention/AIDS education) via letters and newsletters sent to them.

Additional Questions

The 1997 Iowa YRBS and 1998 Iowa SHEP provide an information basis for the HIV needs assessment. However, these surveys were not specifically developed to provide information for an HIV training/education needs assessment. Additional questions to be addressed include:

- What specific curricula do lead health education teachers use in teaching students about HIV prevention?
- On what specific topics are lead health education teachers providing information/education in the areas of basic facts, skill development, and attitude development?
- Did lead health education teachers complete the entire curriculum? If not, why was it not completed?
- What teaching strategies or classroom activities were used?
- What methods were used to help students gain experience with HIV risk reduction?

- How comfortable were the lead health education teachers in discussing with or teaching students about the various aspects of HIV or pregnancy prevention?
- How recent was the lead health education teacher's HIV curriculum training, what was the specific curriculum training, and by whom was it provided?
- In what areas of basic facts, skill development, and attitude development do lead health education teachers need more HIV training?
- How far would the lead health education teachers be willing to travel to get this training?
- Are parental permission letters sent out prior to teaching about HIV infection or AIDS?
- Are parents involved in the lessons on HIV infection or AIDS (e.g., family assignments)?
- Is information about HIV infection or AIDS provided the parents?

The instrument used in conducting the 1999-2000 Iowa HIV training/education needs assessment for middle, junior/senior high, and senior high schools was developed by the author and Sara Peterson, HIV/AIDS Education Project at the Iowa Department of Education, in consultation with HIV and health professionals in Des Moines. The survey was field tested with a small sample of health education teachers in the Des Moines area. Revisions were made based on the feedback from this field test.

Methodology

The 1999-2000 Iowa HIV training/education needs assessment instrument for middle, junior/senior high, and senior high schools consisted of 25 questions (Appendix A). It was developed with input from health consultants at the Iowa Department of Education, evaluation consultants at the Centers of Disease Control and Prevention (CDC), and educators from middle and high schools in Iowa. A template for developing goals and objectives was utilized in this process (Appendix B). This was based on a four step approach to needs assessment (Mehrens & Lehman, 1984). The instrument was developed from this completed template of goals and objectives.

The educators provided input via a field test administered to seven lead health education teachers (LHETs) at the high school level and three LHETs at the middle school level. This yielded information which was used to improve the instrument.

1. Sampling Procedure

The HIV needs assessment was conducted simultaneously with the 2000 Iowa School Health Education Profile (SHEP) (Veale, 2001). Schools were selected for the SHEP using systematic equal probability sampling with a random start. This process yielded 349 schools — slightly over 50% of the number of schools (673) in the population of middle, junior/senior high, and senior high schools in Iowa. *PCSchool*, software provided by Westat, Inc., was used to select the sample of

349 from a sampling frame consisting of all 673 schools. The sample for the SHEP was verified by Westat, Inc.

The HIV needs assessment sample consisted of all remaining schools. By subtraction, this yielded 324 (= 673 - 349) schools — slightly under 50% of the number of schools in the population. Two of these were determined to be ineligible, which yielded a total sample 322 (= 324 -2) eligible schools. This "random partition" of the sampling frame or population was judged to be the most efficient way to conduct both samples.

There were several advantages to the above approach:

- The samples are *both* random, which can produce results that are generalizable to the population of middle, junior high, and senior high schools in Iowa.
- Since the SHEP and HIV needs assessment sampling fractions were close to 50%, the margins of error should be low in each survey.[2]
- Since we will be sampling different principals and/or teachers in the two surveys there will be no way for confusion to develop between the two surveys and response in each should be higher (since nobody will have to take both).

There were no apparent disadvantages, other than the fact that a survey (one or the other) had to be sent to every one of the schools in the population, yielding somewhat higher mailing costs.

The superintendents and principals in the schools sampled were then contacted. A cover letter was sent to each, along with a copy of the survey. The principal was asked to select one lead health education teacher (LHET) to complete the survey in the school. This was to have been someone who was in charge of health education in the school.

Usable data were received from 275 out of 322 eligible sampled schools. This yielded a response rate for the HIV needs assessment survey of 85.4%. This response rate was well above the minimum (70%) set by the CDC for making inferences about the populations and ensures the generalizability of the results to all schools at these grade levels in Iowa. *Moreover, this very high response rate was taken as evidence that the lead health education teachers in Iowa (and their principals) valued the information that was being gathered via the survey.*

The breakdown by school grade level is presented in Table 2. These sample sizes should be considered when it is necessary to break down data on certain questions by school grade level (when differences in responses were statistically significant). Moreover, in particular questions, the sample sizes may be smaller due to selective nonresponse. The statistical effect of such breakdowns is wider confidence intervals. Thus, we feel that overall results using the total sample (yielding shorter confidence intervals) should be used unless grade level differences preclude it.

[2] The SHEP sampling fraction was chosen to make the margin of error no more than 5%. The margin of error for the HIV needs assessment should also be around 5%.

Table 2: Sample size breakdown by school grade level

Sample/Population	Middle Schools[a]	Junior/Senior High Schools	Senior High Schools	Size (n and N)
HIV Needs Assessment Sample	109 (39.6%)	53 (19.3%)	113 (41.1%)	275
Public Schools in Iowa with Grade 6 or Higher (Population)	269 (40.0%)	119 (17.7%)	285 (42.3%)	673

[a] Junior high schools (including 7th, 8th, and sometimes 6th or 9th grades) are also included in this category.

The percentage distribution for the sample was very close to that of the population. The middle school percentage was off by less than 1% and the junior/senior high and senior high school percentages were off by 1-2%. A "goodness of fit" chi-square test yielded no significant difference ($P = .784 > .05$). This is taken as further evidence of the representativeness of the sample and the generalizability of the results.[3]

2. Data Analysis

The primary focus in data analysis is the estimation of population parameters, namely the proportion of lead health education teachers (LHETs) with the various health education attributes and needs assessed in the questionnaires. Tests of statistical significance were conducted on data from each of the survey questions to assess the feasibility of reporting results for the total sample versus reporting results by school grade level. For example, Question 14 concerning whether parental permission letters were sent out prior to teaching about HIV/AIDS yielded an affirmative response among 49% of middle school LHETs, 34% of those in junior/senior high school, and just 25% of those in senior high school. These differences were statistically significant ($P = .004$). Response data for this question were reported separately for each grade level. On the other hand, in Question 15 regarding parental involvement in the lessons on HIV/AIDS, there were no statistically significant differences ($P > .05$). Here, the response data were reported for all LHETs responding to the survey question.[4]

The Pearson chi-square test was used to test for grade level differences in questions 14 and 15 (and all others with a non-quantitative response). In the 18 sub-items comprising Question 8, the

[3] This result was obtained after "cleaning" the data by adjusting responses to this question to fit the knowledge based on the state level information concerning the actual grade range of the school in question. (The school names were written on the surveys before mailing them out.) In some cases, the respondent appeared to indicate the particular grade(s) he/she was teaching (rather than the actual grade range of the school). Moreover, some "high schools" were actually junior/senior high schools and some junior high schools were mistakenly grouped with junior/senior high schools. (Junior high schools were included with middle schools since they all included some or all of grades 6-9, but not higher grades.) Since the sampling fraction was close to 50% and the response rate was very high (over 85%), we expected the percentages for the sample and population to be close or at least not significantly different ($P > .05$). In fact, there were practically no differences whatever ($P = .784$).

[4] In the "all-that-apply" questions, where the respondent is requested to check as many of the responses provided as apply to her/his opinion or situation, no formal statistical test was conducted. In these cases, a judgement was made concerning the degree of the differences in the percent of each response across the three grade level categories.

response data are quantitative (with numeric values 1 to 4). The Kruskal-Wallis nonparametric test was employed to test for grade level differences on the sub-items of this question, due to the presence of outliers in several of these — evidence of serious non-normality. In addition, an item analysis was conducted to examine the internal consistency reliability of these sub-items as a scale measuring "comfort" with various HIV-related topics. In all cases, exact methods were used to compute P-values. The following software packages were employed: *ABstat* (Anderson-Bell Corp) for data entry and count distributions, *Number Cruncher* (NCSS, Dr. Jerry Hintze) for the item analysis, and *StatXact* (CYTEL Software Corporation) for the exact tests and P-values.[5]

In all of these analyses, the "blank responses" (those omitting the question) were ignored and percentages computed based on the actual responses to the question. These actual responses constitute the effective sample sizes for each question. These effective sample sizes are presented in Appendix C.

Results: Determining the HIV Training/Education Needs

The results of the survey are presented below. If no grade level breakdown is mentioned, either the differences were not statistically significant (P > .05) or, in the case of all-that-apply questions, the judgement was made that these differences were not substantial enough to warrant such a statistical break out.

1. HIV Curriculum

Section 1 consists of the following questions regarding HIV curriculum.

Question 1: What curriculum do you use in teaching children about HIV prevention education? (Check all that apply.)

Of the 270 LHETs responding to this question, 199 or 73.7% selected "Teacher-developed curriculum." This was far and away the most frequently selected answer choice. "Other" was second with 78 responses or 28.9%, including "Totally Awesome Health," "Wedge – by State of Iowa," and "Weekly Reader – What You Need to Know," *inter alia*.

Question 2: In which of the following *basic facts areas* have you provided information or education? (Check all that apply.)

All answer choices were selected by 70% or more of the 273 LHETs responding to this question. The most frequently selected were "Facts about HIV and HIV prevention methods" (268 or 98.2%), "Facts about other STDs and prevention" (258 or 94.5%), "Facts about sexual abstinence" (249 or 91.2%), and "Injection drug use and HIV" (238 or 87.2%).

Question 3: In which of the following *skill areas* have you provided information or education? (Check all that apply.)

[5] We had originally planned to conduct "weighted" analyses using software that would adjust for differences due to size of school. The software package that we were planning to use was not available in time for this report. Typically, weighting the data produces estimates that are within one or two percent of the unweighted percentages. Since the precise numeric value is considered less important than *patterns of response* (e.g., differences over groups or most frequent selections) in needs assessments, this was not considered critical.

Of the 266 LHETs responding to this question, "Partner communication skills ..." was the most frequently selected with 207 responses or 77.8%. This was followed by "Handling high risk situations" (186 or 69.9%), "Talking with parents" (180 or 67.7%), "Negotiation skills used for refusing sex" (173 or 65.0%), and "Nonverbal skills used for refusing sex" (166 or 62.4%).

Question 4: In which of the following *attitudinal areas* have you provided information or education? (Check all that apply.)

Of the 267 LHETs responding to this question, "Perception of vulnerability to STDs, including HIV/AIDS" was most frequently selected with 230 responses or 86.1%. Second most selected was "Realistic portrayal ... of teenage pregnancy" with 201 responses or 75.3%, followed by "Perception of vulnerability to ... unwanted pregnancy" (189 or 70.8%), "Compassion and support for people living with HIV/AIDS" (186 or 69.7%), and "Realistic portrayal of health and lifestyle impact of AIDS" (180 or 67.4%).

Question 5: Were you able to complete the entire HIV curriculum?

Of the 263 LHETs responding to this question, 139 or 52.9% indicated that they were able to complete the entire curriculum, while another 63 or 24.0% indicated that HIV was "infused into one or more subject areas."

Among the 61 who responded to the follow-up question, the most important reasons for not completing the curriculum were "Lack of time due to workload" (39 or 63.9%) and "Scheduling difficulties" (30 or 49.2%).

Question 6: What teaching strategies or classroom activities do you use? (Check all that apply.)

Of the 273 LHETs responding to this question, "Lecture" was selected most frequently with 260 responses or 95.2%, followed by "Discussion" (243 or 89.0%), "Small group work" (199 or 72.9%), "Reading assignments" (190 or 69.6%), and "Writing assignments" (189 or 69.2%).

Question 7: What methods do you use to help your students become more experienced in *risk reduction skills*? (Check all that apply.)

Of the 247 LHETs responding to this question, "Group processing" was selected most frequently with 180 responses or 72.9%, followed by "Role playing" (130 or 52.6%) and "Skills practice" (116 or 47.0%). In addition, "Peer educators" was selected by 63 or 25.5% of the LHETs.

Question 8: How comfortable are you in discussing or teaching about the following HIV/AIDS and pregnancy prevention topics with your students? (Circle ONE response for each topic listed.)

This question includes 18 topics that relate to HIV/AIDS and/or pregnancy prevention, such as basic facts and statistics about STDs and HIV, sexual behaviors that transmit STDs and HIV, injection drug use behaviors that transmit HIV, basic facts about condoms, support and compassion for persons living with HIV/AIDS, gender orientation issues, etc. The responses constituted a numeric rating scale: "Very Uncomfortable" (1), "Somewhat Uncomfortable" (2), "Somewhat Comfortable" (3), and "Very Comfortable" (4). A total score was computed and an "item analysis" conducted. All 18 items had correlation with the total score (omitting the item in question) that exceeded .65. The Cronbach's alpha was 0.981, indicating excellent internal consistency reliability for this 18 item scale.

The means for the items ranged from 2.927 (gender orientation issues) and 3.164 (basic facts about condoms) to 3.613 (basic facts and statistics about SDSs and HIV) and 3.608 (basic information about STD and HIV prevention). (See Figure 1.) Thus, on these critical HIV-related topics, there was an average comfort level ranging from slightly less than "Somewhat comfortable" (gender orientation issues) to a little over halfway between "Somewhat" and "Very" comfortable (basic facts and information).

2. Training Needs

Section 2 consists of the following questions regarding HIV training needs.

Question 9: Have you received any HIV curriculum training during the past two years?

Of the 273 LHETs responding to this question, 31 or 27.4% of senior high school LHETs, 21 or 19.6% of middle school LHETs, and only 5 or 9.4% of junior/senior high school LHETs responded affirmatively. These differences were statistically significant (P = .026).

Of those responding affirmatively, 56 responded to the follow-up question regarding the type of training they had received. "Other" was the most frequent response to this question, including

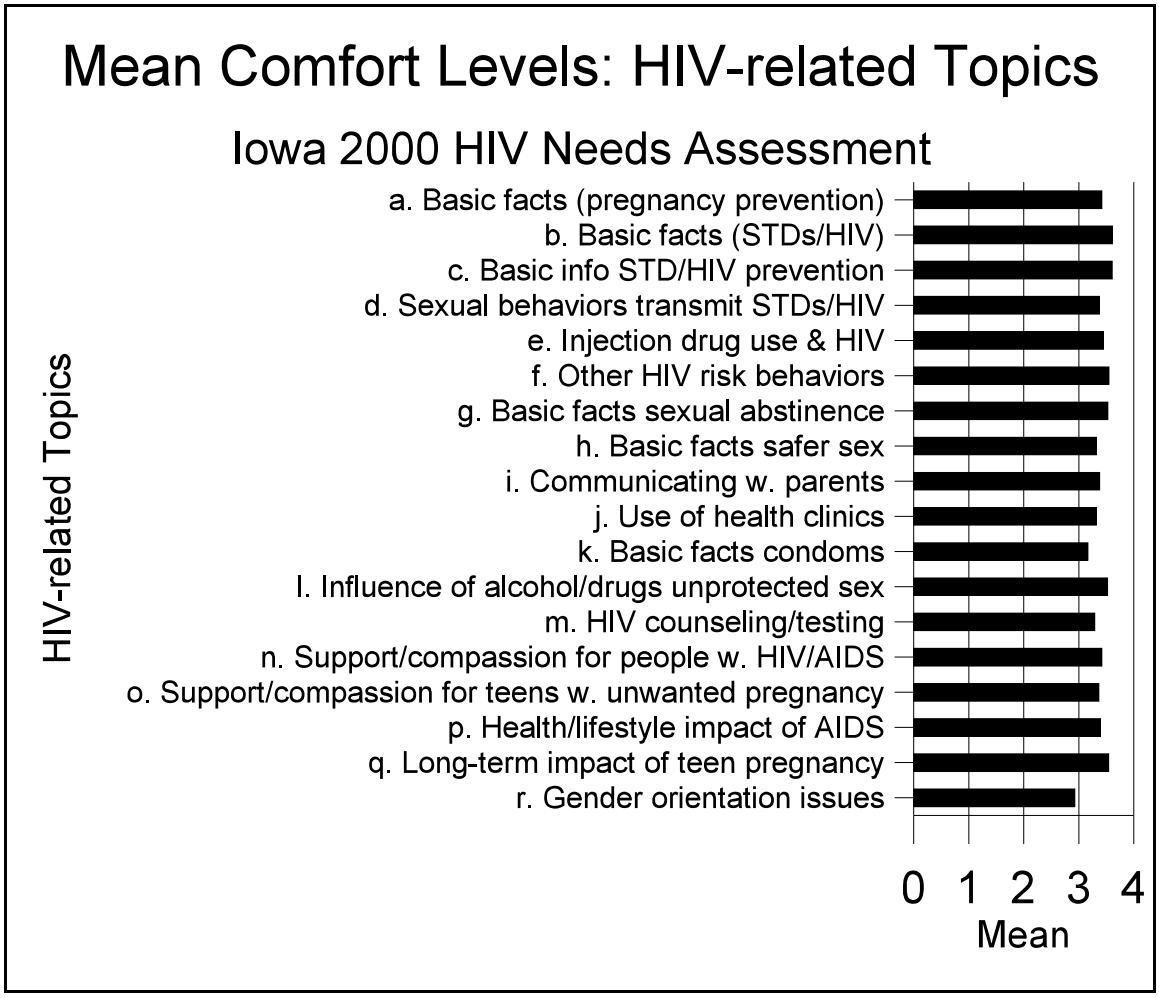

Figure 3: Mean comfort levels on HIV-related topics.

"conference offered by IDPH (Iowa Department of Public Health)," "Story County AIDS Coalition," and "Health Clinic Training," *inter alia*. This was followed by "Get Real About AIDS" (15 or 26.8%) and "Basic Facts" (12 or 21.4%).

Fifty-two responded to another follow-up question regarding the organization providing the training. Among these organizations, the Area Education Agency (AEA) was the most frequently selected (20 or 38.5%).

Question 10: In which of the following *basic facts areas* do you need more training? (Check all that apply.)

Of the 189 responding to this question, the most frequently selected basic facts areas were "Injection drug use and HIV" (101 or 53.4%), "Facts about HIV and HIV prevention" (82 or 43.4%), "Facts about other STDs and prevention" (75 or 39.7%), "HIV and the use of alcohol and other drugs" (75 or 39.7%), and "Safer sex facts" (72 or 38.1%).

Question 11: In which of the following *skill areas* do you need more training? (Check all that apply.)

Of the 239 responding to this question, the most frequently selected skill areas were "Talking with parents" (120 or 50.2%), "Handling high risk situations" (115 or 48.1%), "Cleaning needles and syringes" (102 or 42.7%), "Partner communication skills ..." (101 or 42.3%), "Nonverbal skills used for refusing sex" (98 or 41.0%), and "Negotiation skills used for refusing sex" (94 or 39.3%).

Question 12: In which of the following *attitudinal areas* do you need more training? (Check all that apply.)

Of the 212 responding to this question, the most frequently selected attitudinal areas were "Gender orientation issues" (130 or 61.3%), "Realistic portrayal of the health and lifestyle impact of AIDS" (98 or 46.2%), and "Perceived vulnerability to STDs, including HIV/AIDS" (81 or 38.2%).

Question 13: How far would you be willing to travel for this training?

Of the 252 responding to this question, most selected "No more than 50 miles" (170 or 67.5%).

3. Parental Involvement in the HIV Curriculum

Section 3 consists of the following questions regarding parental involvement in the HIV curriculum.

Question 14: Are parental permission letters sent out prior to teaching the HIV/AIDS unit?

Of the 261 LHETs responding to this question, 49 or 48.5% of middle school LHETs, 17 or 34.0% of junior/senior high school LHETs, and only 27 or 24.5% of senior high school LHETs responded affirmatively. These differences were statistically significant ($P = .003$). Thus, middle school health education teachers were twice as likely to respond that they sent out permission letters to parents prior to teaching about HIV/AIDS as were senior high school health education teachers. (See Figure 2.)

Question 15: Are parents involved in the lessons on HIV/AIDS (e.g., via family assignments)?

Of the 267 LHETs responding to this question, only 43 or 16.1% responded affirmatively.

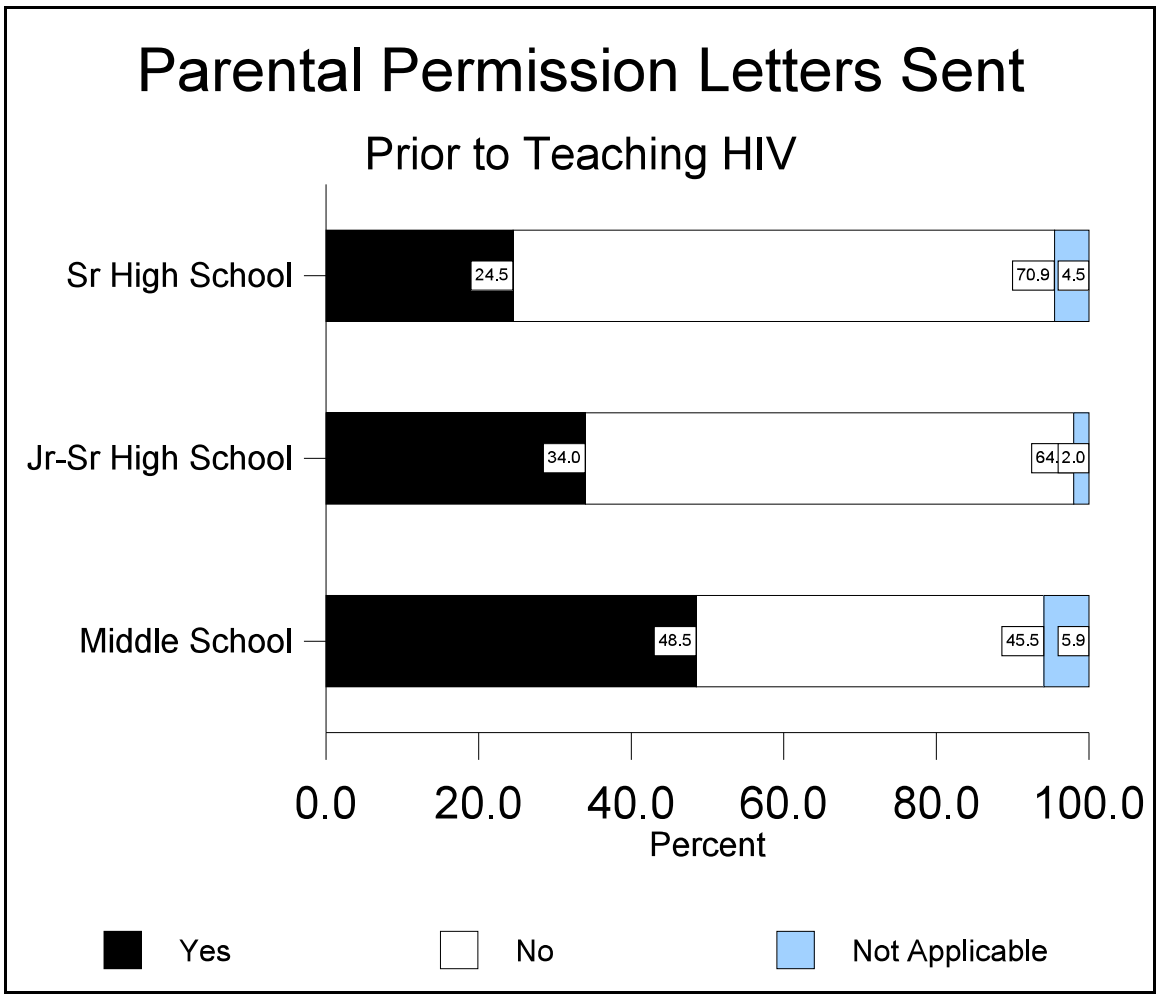

Figure 4: Parent permission letters sent prior to teaching, broken down by grade level.

Question 16: Do you provide information about HIV/AIDS to parents (e.g., pamphlets or newsletters)?

Of the 268 LHETs responding to this question, only 61 or 22.8% responded affirmatively.

4. Background Information

Section 4 consists of the following questions concerning background information on the LHETs.

Question 17: Are you responsible for teaching the entire health curriculum or individual components of the curriculum?

There were statistically significant differences among grade level categories on this question, with 85 or 78.0% of senior high school LHETs indicating they were responsible for teaching the entire health curriculum, 37 or 71.2% of junior/senior high school LHETs, and 53 or just 52.5% of middle school LHETs so indicating (P = .0003).

Question 18: What is your professional background area?

Of the 273 LHETs responding to this question, the most frequently selected background areas were health education (173 or 63.4%) and physical education (137 or 50.2%), followed by family life education or life skills (66 or 24.2%).

Question 19: How long have you been teaching HIV/AIDS?

Of the 271 LHETs responding to this question, about two-thirds (182 or 67.2%) indicated they had been teaching HIV/AIDS for more than 5 years and one-sixth (46 or 17.0%) indicated they had been involved in HIV/AIDS education for 3-5 years.

Question 20: What grade level are you teaching? (Check all that apply.)

Of the 273 LHETs responding, just under two-thirds (176 or 64.5%) said they were teaching in grades 9-12, while just over half (146 or 53.5%) said they were teaching grades 6-8. Forty-nine LHETs (17.9%) indicated they were teaching at both levels.

Question 21: How long do you spend on HIV? (Please check one.)

Of the 264 LHETs responding to this question, 150 (56.8%) indicated they were spending 2-4 class sessions and 98 (37.1%) indicated they were spending 5 or more class sessions on HIV.

Question 22: Has the HIV curriculum you are using been approved or adopted by the local school board? (Check one.)

Of the 269 LHETs responding to this question, 150 (55.8%) responded affirmatively. Omitting the 70 who selected "Don't know," 75.4% responded "Yes" and 24.6% "No."

Question 23: What sources do you use to determine the health needs of your students? (Check all that apply.)

Of the 256 LHETs responding to this question, "Conversations with students" was most frequently selected (200 or 78.1%) followed by "Information from counselors" (134 or 52.3%). The Youth Risk Behavior Survey (YRBS) drew only 37 LHETs or 14.5%.

Question 24: Approximately what percent of your students choose to opt out of your class or have an alternative program?

Of the 262 LHETs responding to this question, more than two-thirds indicated that none opted out (179 or 68.3%), while 74 (28.2%) said "1-10%."

5. Summary Question

At the end of Section 4 was the following summary question.

Question 25: How is the emphasis of the HIV curriculum you are using and your teaching style divided between information dissemination and skills development? (Check one.)

The choices ranged from "Information only" to "Skills and practice only." More than half of the 267 LHETs responding to this question indicated they were using "Mostly information" (152 or 56.9%). This was followed by "Equally divided" (between information and skills/practice) with 94 responses or 35.2%.

Discussion: Analyzing the HIV Training/Education Needs

In this section we will focus on analyzing the HIV training and education needs of the middle, junior/senior high, and senior high schools in Iowa, based on the results summarized in the previous section. The analysis consists of four components, as follows:

- comparison of the results of questions 2,3, and 4 with questions 10, 11, and 12, respectively;
- results from Question 8 on "comfort" level with various HIV-related topics;
- results on questions 14-16 dealing with parental involvement in the HIV curriculum;
- results on Question 25 regarding the emphasis on information versus skills and practice.

1. Comparison: Topics on which Information/Education is Provided and Topics on which Training is Needed

The approach to needs assessment analysis used in this component is similar to "discrepancy analysis" where two types of responses are compared — *what is* (being done) and *what should be* (or is required or desired) (Altschuld & Witkin, 2000). In our survey, the "what is" concerning HIV curriculum was measured in questions 2,3, and 4, while the "what should be (is required, desired)" was measured in questions 10, 11, and 12. It was assumed that if the respondent indicated that training was needed in a particular curricular area that this was either "required" or "desired" by the respondent to help them to deliver that information, develop that skill, or foster that attitude in the students.

Comparing the results of Question 2 with those of Question 10, there were three topics most frequently selected in each: "Injection drug use and HIV," "Facts about HIV and HIV prevention," and "Facts about other STDs and prevention." This probably indicates a need for updates in these areas. On the other hand, "HIV and the use of alcohol and other drugs" and "Safer sex facts" were not frequently selected topics on which information/education was provided but were frequently selected topics on which training was needed. These are areas in which the need for more comprehensive training is indicated.

Comparing the results of Question 3 with those of Question 11, it is interesting to note that there was nearly perfect agreement on the topics: "Talking with parents," "Handling high risk situations," "Partner communication skills ...," "Nonverbal skills used for refusing sex," and "Negotiation skills used for refusing sex" were all frequently selected in both questions. This probably indicates a need for updates in these areas. On the other hand , "Cleaning needles and syringes" was frequently selected as an area in which training was needed (but on which few were providing information or education). This is an area in which there is an indication of a need for more comprehensive training.

Finally, comparing the results of Question 4 with those of Question 12, there were two topics frequently selected in each: "Realistic portrayal of the health and lifestyle impact of AIDS" and "Perceived vulnerability to STDs, including HIV/AIDS." This probably indicates a need for updates in these areas. On the other hand, "Gender orientation issues" was the most frequently selected as an area in which training was needed (but on which relatively few were providing infor-

mation or education). This is an area in which there is an indication of a need for more comprehensive training.

2. Comfort Level Regarding HIV-related Topics

The sample mean of the average scores on the 18 sub-items of Question 8 was 3.41. Thus, on the average, LHETs were somewhere about midway between "Somewhat Comfortable" and "Very Comfortable" on these questions — their overall "comfort level" on these topics.

The only topic (sub-item) on which the LHETs averaged lower than 3 ("Somewhat Comfortable") was "Gender orientation issues." Also, on "Basic facts about condoms" they averaged only slightly above 3 ("Somewhat Comfortable"). These are two of the more sensitive issues related to HIV prevention and education. There is a need to raise the comfort level of the lead health education teachers on these topics.

3. Parental Involvement in the HIV Curriculum

Parental permission letters prior to teaching the HIV/AIDS unit were more likely to be sent to parents of middle school students (just under 50%) than to those of junior/senior high school students, who in turn were more likely to be sent such letters than parents of senior high school students. This is evidence of at least passive involvement by parents in decisions involving what schools may teach their children concerning this serious health risk — especially for parents of middle (including junior high) school students.

On the other hand, less than one in four parents received information about HIV/AIDS and only about one in six were involved in lessons on HIV/AIDS (such as family assignments). Parent or family involvement is viewed as an important factor in education (e.g., Senge et al, 2000). The parent is considered one of the three primary components of the "system" that constitutes a learning classroom and school (ibid.). This applies to HIV education as with other more traditional subjects taught in the classroom. Moreover, the National Coalition for Parent Involvement in Education (1992) recommended a "comprehensive reciprocal approach to family-school partnerships" incorporating the following:

- parents and schools as communicators;
- parents and schools as supporters;
- parents and schools as learners;
- parents and schools as teachers;
- parents and schools in shared governance.

All three of the questions in the section on parent involvement in the HIV curriculum would fall into some or all of these conceptual categories. Evidently, parental involvement in the HIV curriculum is an area in which there is a need for improvement.

4. Emphasis on Information Dissemination versus Skills Development in the HIV Curriculum and Teaching Style

Most LHETs (over half) indicated the HIV curriculum and teaching style they were using emphasized mostly information dissemination. A little over one-third indicated that the curriculum and teaching style used was about equally divided between information and skills development and practice. Since the current priority of the Centers for Disease Control and Prevention (CDC) is on

increasing skills development and practice in HIV prevention, there is some evidence of need for improvement in this area.

Discussion: Prioritizing the HIV Training/Education Needs

There are a variety of approaches that have been suggested for setting priorities for the needs that have been determined and analyzed (Altschuld & Witkin, 2000). Two promising approaches for prioritizing HIV training/education needs are (1) Sork's approach using importance and feasibility criteria (Sork, 1995) and (2) a risk assessment approach.

Sork's approach given in Altschuld and Witkin (2000) utilizes the following importance criteria:

- number of individuals affected (by the need);
- contribution (of resolving the need) to organizational goals;
- degree to which immediate attention required (to resolve the need);
- magnitude of discrepancy (between "what is" and "what should be");
- effect of resolving the need on other areas;

and the following feasibility criteria:

- educational intervention contributes to reducing or resolving the need;
- availability of resources for programs to reduce or resolve the need;
- commitment or willingness of organization(s) to change.

Each of these components is rated on a 1-5 scale, with larger values indicating greater importance or feasibility. Some components may be given greater weight than others. Weighted sums and means may be obtained for each assessor and then averaged over them.

The risk assessment criteria given by Altschuld and Witkin (2000) are as follows:

- Is the need really worth the effort?
- What are the short-term negative economic consequences for the organization of not attending to the need?
- What are the long-term negative economic consequences for the organization of not attending to the need?
- Will the risk increase with the passage of time?
- Will new developments reduce the risk?
- What are the short-term negative political consequences of not attending to the need?
- What are the long-term negative political consequences of not attending to the need?
- Will our competitors be in a stronger position if we do not attend to the need?
- Will attending to the need be disruptive to internal operation of the organization?

- Will the culture of the organization preclude the ability to adjust and buy into the changes necessary to resolve the need?

As with Sork's approach, each component is rated on a 1-5 scale, with larger values indicating greater risk (higher priority need). Also, numbers may be assigned to each question to give greater weight to some components than to others. Weighted sums and means may be obtained for each assessor and then averaged over them. According to Altschuld and Witkin (2000, pp. 129-130), this approach may be useful for needs prioritization in the area of HIV/AIDS. However, they indicated that it has seen little application in any area to date, while Sork's approach seems applicable to a variety of situations.

An informal prioritization of HIV training/education needs was conducted prior to the needs analysis, in consultation with Sara Peterson, HIV/AIDS consultant in the Iowa Department of Education. This yielded the four components of the analysis presented in the previous section. A more formal prioritization should be conducted using Sork's approach, risk assessment, or some other approach by a needs assessment committee. The same group that met to plan and develop the needs assessment goals and objectives can be used to prioritize needs. This is planned as part of a follow-up to this report and as a precursor to developing strategies for taking action to reduce or resolve these needs ("post-assessment").

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APPENDIX A

1999-2000 Iowa HIV Training/Education Needs Assessment Instrument

2000 Iowa HIV Training/Education Needs Assessment

In order to assess the training and/or education needs of lead health education teachers in the area of HIV prevention education, we request that you answer the following questions.

Please indicate the type of school and grade level of students served.

__ a. Middle school (grades: ___ to ___)
__ b. Junior/senior high school (grades: ___ to ___)
__ c. Senior high school (grades: ___ to ___)

School Name: _____ Survey ID: _____

Section 1: *HIV curriculum*

1. What curriculum do you use in teaching students about HIV prevention education? (Check all that apply.)
   __ a. Power Moves
   __ b. Be Proud Be Responsible
   __ c. Get Real About AIDS
   __ d. Reducing the Risk
   __ e. Act Smart
   __ f. Basic Facts
   __ g. Prevention Skills
   __ h. Teacher-developed curriculum
   __ i. District-developed curriculum
   __ j. Other (please write in): _____

Answer questions 2-6 concerning your HIV curriculum.

2. In which of the following *basic facts areas* have you provided information or education? (Check all that apply.)
   __ a. Facts about pregnancy prevention methods
   __ b. Facts about HIV and HIV prevention
   __ c. Facts about other STDs and prevention
   __ d. Injection drug use and HIV
   __ e. HIV and the use of alcohol and other drugs
   __ f. Facts about sexual abstinence
   __ g. Safer sex facts
   __ h. Other (please specify): _____

3. In which of the following *skill areas* have you provided information or education? (Check all that apply.)
   __ a. Partner communication skills about love, sex, protection, and relationships
   __ b. Talking with parents
   __ c. Nonverbal skills used for refusing sex
   __ d. Negotiation skills used for refusing sex
   __ e. Handling high risk situations
   __ f. Skills to obtain HIV testing/counseling
   __ g. Use of local health clinics
   __ h. Skills to acquire condoms
   __ i. Correct use of condoms
   __ j. Cleaning needles and syringes
   __ k. Other (please specify): _____

4. In which of the following *attitudinal areas* have you provided information or education? (Check all that apply.)
   - __ a. Compassion and support for people living with HIV/AIDS
   - __ b. Support and empathy for teenagers who have unwanted pregnancy
   - __ c. Perception of vulnerability to STDs, including HIV/AIDS
   - __ d. Perception of vulnerability to an unwanted pregnancy
   - __ e. Realistic portrayal of the health and lifestyle impact of AIDS
   - __ f. Realistic portrayal of the long-term impact (e.g., completing school, career choices) of teenage pregnancy
   - __ g. Gender orientation issues
   - __ h. Other (please specify): _____

5. Were you able to complete the entire HIV curriculum?
   - __ a. Yes
   - __ b. No
   - __ c. Other — infused into one or more subject areas

   If "No," what were the reasons? (Check only the most important ones.)
   - __ a. Scheduling difficulties
   - __ b. Inadequate training in curriculum
   - __ c. Lack of time due to workload
   - __ d. Not comfortable teaching about certain sensitive topics
   - __ e. Lack of administrative support
   - __ f. Concern that student would not be receptive to the curriculum
   - __ g. Concern that parents would not be supportive
   - __ h. Belief that some curriculum content/topics (e.g., prevention strategies for sexually active youth) should not be taught in public schools
   - __ i. Not enough time for students to practice skills
   - __ j. Other (please specify): _____

6. What teaching strategies or classroom activities do you use? (Check all that apply.)
   - __ a. Lecture
   - __ b. Role play
   - __ c. Brainstorming
   - __ d. Writing assignments
   - __ e. Interactive theater
   - __ f. Small group work
   - __ g. Skills modeling
   - __ h. Journaling
   - __ i. HIV positive speakers
   - __ j. Discussion
   - __ k. Case studies
   - __ l. Reading assignments
   - __ m. Peer educators
   - __ n. Group processing
   - __ o. Question box
   - __ p. Skills practice
   - __ q. Research projects (individual or group)
   - __ r. Other (please specify): _____

7. What methods do you use to help your students become more experienced in *risk reduction skills*? (Check all that apply.)
   - __ a. Peer educators
   - __ b. Skills practice
   - __ c. Interactive theater
   - __ d. Role playing
   - __ e. Journaling
   - __ f. Group processing
   - __ g. Other (please specify): _____

8. How comfortable are you in discussing or teaching about the following HIV/AIDS and pregnancy prevention topics with your students? (Circle ONE response for each topic listed.)

Topics	Very Uncomfortable (1)	Somewhat Uncomfortable (2)	Somewhat Comfortable (3)	Very Comfortable (4)
a. Basic facts about pregnancy prevention methods	1	2	3	4
b. Basic facts and statistics about STDs and HIV	1	2	3	4
c. Basic information about STD and HIV prevention	1	2	3	4
d. Sexual behaviors that transmit STDs and HIV	1	2	3	4
e. Injection drug use behaviors that transmit HIV	1	2	3	4
f. Other HIV risk behaviors (e.g., cleaning spilled blood, breast-feeding by infected mother)	1	2	3	4
g. Basic facts about sexual abstinence	1	2	3	4
h. Basic facts about safer sex	1	2	3	4
i. Communicating with parents	1	2	3	4
j. Use of local health clinics	1	2	3	4
k. Basic facts about condoms	1	2	3	4
l. Influence of alcohol and other drugs on unwanted or unprotected sex	1	2	3	4
m. HIV counseling and testing	1	2	3	4
n. Support and compassion for persons living with HIV/AIDS	1	2	3	4

Topics	Very Uncomfortable (1)	Somewhat Uncomfortable (2)	Somewhat Comfortable (3)	Very Comfortable (4)
o. Support and compassion for teenagers who have unwanted pregnancy	1	2	3	4
p. Health and lifestyle impact of AIDS	1	2	3	4
q. Long-term impact of teenage pregnancy (e.g., completing school, career choices)	1	2	3	4
r. Gender orientation issues	1	2	3	4

Section 2: *Training needs*

9. Have you received any HIV curriculum training during the past two years?
   - __ a. Yes
   - __ b. No

   If "No," go on to question 10; if "Yes":

   A. What HIV curriculum training did you receive during the past two year? (Check all that apply.)
      - __ a. Power Moves
      - __ b. Be Proud Be Responsible
      - __ c. Get Real About AIDS
      - __ d. Reducing the Risk
      - __ e. Act Smart
      - __ f. Basic Facts
      - __ g. Prevention Skills
      - __ h. Other (please write in): _____

   B. By whom was this training provided? (Check all that apply.)
      - __ a. Area Education Agency (AEA)
      - __ b. Iowa Department of Public Health
      - __ c. Iowa Department of Education
      - __ d. Community organization (Red Cross, etc.)
      - __ e. Other (please specify): _____

10. In which of the following *basic facts areas* do you need more training? (Check all that apply.)
    - __ a. Facts about pregnancy prevention methods
    - __ b. Facts about HIV and HIV prevention
    - __ c. Facts about other STDs and prevention
    - __ d. Injection drug use and HIV
    - __ e. HIV and the use of alcohol and other drugs
    - __ f. Facts about sexual abstinence
    - __ g. Safer sex facts
    - __ h. Other (please specify): _____

11. In which of the following *skill areas* do you need more training? (Check all that apply.)
    __ a. Partner communication skills about love, sex, protection, and relationships
    __ b. Talking with parents
    __ c. Nonverbal skills used for refusing sex
    __ d. Negotiation skills used for refusing sex
    __ e. Handling high risk situations
    __ f. Skills to obtain HIV testing/counseling
    __ g. Use of local health clinics
    __ h. Skills to acquire condoms
    __ i. Correct use of condoms
    __ j. Cleaning needles and syringes
    __ k. Other (please specify): _____

12. In which of the following *attitudinal areas* do you need more training? (Check all that apply.)
    __ a. Compassion and support for people living with HIV/AIDS
    __ b. Support and empathy for teenagers who have unwanted pregnancy
    __ c. Perception of vulnerability to STDs, including HIV/AIDS
    __ d. Perception of vulnerability to an unwanted pregnancy
    __ e. Realistic portrayal of the health and lifestyle impact of AIDS
    __ f. Realistic portrayal of the long-term impact (e.g., completing school, career choices) of teenage pregnancy
    __ g. Gender orientation issues
    __ h. Other (please specify): _____

13. How far would you be willing to travel for this training?
    __ a. No more than 50 miles
    __ b. No more than 100 miles
    __ c. Anywhere in the state

Section 3: *Parental involvement in the HIV curriculum*

14. Are parental permission letters sent out prior to teaching the HIV/AIDS unit?
    __ a. Yes
    __ b. No
    __ c. Not applicable

15. Are parents involved in the lessons on HIV/AIDS (e.g., via family assignments)?
    __ a. Yes
    __ b. No
    __ c. Not applicable

    If "Yes," how are parents involved in these lessons? _____

16. Do you provide information about HIV/AIDS to parents (e.g., pamphlets or newsletters)?
    __ a. Yes
    __ b. No
    __ c. Not applicable

Section 4: *Background information*

17. Are you responsible for teaching the entire health curriculum or individual components of the curriculum?
    __ a. Entire curriculum
    __ b. Individual component(s) (please write in): _____

18. What is your professional background area?
    __ a. Physical education
    __ b. Health education
    __ c. Social studies
    __ d. Family life education or life skills
    __ e. Science
    __ f. Nursing
    __ g. Counseling
    __ h. Other (please write in): _____

19. How long have you been teaching HIV/AIDS?
    __ a. 0 years (first year teaching HIV/AIDS)
    __ b. 1 to 2 years
    __ c. 3 to 5 years
    __ d. More than 5 years

20. What grade level are you teaching? (Check all that apply.)
    __ a. Grades 6 - 8
    __ b. Grades 9 - 12

21. How long do you spend on HIV? (Please check one.)
    __ a. Single class session
    __ b. 2 to 4 class sessions
    __ c. 5 or more class sessions

22. Has the HIV curriculum you are using been approved or adopted by the local school board? (Check one.)
    __ a. Yes
    __ b. No
    __ c. Don't know

23. What sources do you use to determine the health needs of your students? (Check all that apply.)
    __ a. Youth Risk Behavior Survey (YRBS)
    __ b. Conversations with students
    __ c. Teen pregnancy data
    __ d. STD data
    __ e. Information from counselors
    __ f. Other (please write in): _____

24. Approximately what percent of your students choose to opt out of your class or have an alternative program?
    __ a. None
    __ b. 1-10%
    __ c. More than 10% (if more, what percent? _____)

25. How is the emphasis of the HIV curriculum you are using and your teaching style divided between information dissemination and skills development? (Check one.)
    __ a. Information only
    __ b. Mostly information
    __ c. Equally divided
    __ d. Mostly skills and practice
    __ e. Skills and practice only

Thank you very much for your cooperation in completing this survey. The information you have provided will be very helpful to the Department of Education in assessing HIV training and education needs for the schools in Iowa.

APPENDIX B

Template for Goals and Objectives

HIV Needs Assessment: Goals and Objectives

1. List full range of *possible goals and/or objectives* for the needs assessment.

2. Determine the *relative importance* of the goals and/or objectives.

3. Assess the *degree to which the important goals/objectives are being achieved* by the program(s), i.e., identify the discrepancies between desired and actual performance.

4. Determine which of the discrepancies between present and desired performance are the *ones most important to correct.*

(Mehrens and Lehman, 1984)

Points 1 and 2 related to instrument development. Point 3 is the actual surveying of educators. Point 4 relates to the analysis of the data, conclusions, and recommendations.

Goals of the needs assessment:

1. To find out what curriculum is currently being used.

2. To assess parental/community involvement in the HIV and AIDS curriculum.

3. To assess the types and level of training needs for HIV/AIDS education; technical assistance needs.

Objectives of the needs assessment:

Goal 1 objectives:

1. CDC "programs that work" (Be Proud Be Responsible, Get Real, Power Moves, RTR), ARC programs (Act Smart, Basic Facts, Prevention Skills), and district or local programs

   a. Hours per course (HIV/AIDS)

   b. Hours per course (related health issues)

2. Methods used (comfortableness with them)

3. What they are teaching about HIV/AIDS (basic facts about pregnancy prevention, basic facts about HIV and AIDS, etc.)

4. Special education

   a. lessons modified for students in special ed.

   b. taught about HIV?

Goal 2 objectives:

1. Parental consent *before* unit (on HIV/AIDS or related issue) is provided
2. Parents involved in lessons; family assignments
3. Other procedures, e.g., newsletters or pamphlets sent home

Goal 3 objectives:

1. Barriers to HIV/AIDS education
2. Technical assistance needs (from DE and/or AEA)

Additional goals/objectives:

1.
2.
3.

Format for measuring objectives:

1. Multiple-choice
2. Short answer
3. Likert/numeric rating scale
4. Comment-style

Items for measuring objectives:

Goals	Objectives	Items (Instrument #/Item #)[a]
1	1	Instrument 11/Item 6 (may need to add parts for CDC, district, and local curricula)
	2	Instrument 3/Items 75-92
	3	Instrument 3/Items 12-40
2	1	To be developed
	2	To be developed
	3	To be developed
3	1	Instrument 3/Item 44 Instrument 9/Item 29 Instrument 10/Item 6 Instrument 11/Item 13
	2	Instrument 11/Item 14
	3	
Additional goals:		

[a] Instruments and items presented in *Evaluation for Program Improvement: Sample Evaluation Materials for SEA/LEA HIV/AIDS Education Program Staff*, compiled by Evaluation Consultation Center staff of the Academy for Educational Development.

APPENDIX C

Effective Sample Sizes for Survey Questions

Effective Sample Sizes

Question Number	Outcome (Abbreviated)	Effective Sample Size (N)
1	Curriculum used	270
2	Basic facts areas provided	273
3	Skill areas provided	266
4	Attitudinal areas provided	267
5a	Complete entire curriculum	263
5b	Reasons for not completing curriculum	61
6	Teaching strategies/classroom activities	273
7	Methods - risk reduction skills	247
8a	Comfort - basic facts pregnancy prevention	266
8b	Comfort - basic facts about STDs/HIV	274
8c	Comfort - basic information STD/HIV prevention	273
8d	Comfort - sexual behaviors that transmit STDs/HIV	270
8e	Comfort - injection drug use and HIV	273
8f	Comfort - other HIV risk behaviors	273
8g	Comfort - basic facts about abstinence	273
8h	Comfort - basic facts about safer sex	268
8i	Comfort - communicating with parents	270
8j	Comfort - use of local health clinics	266
8k	Comfort - basic facts about condoms	268
8l	Comfort - influence of alcohol & other drugs	270
8m	Comfort - HIV couseling/testing	267
8n	Comfort - support/compassion for persons w. HIV/AIDS	267
8o	Comfort - support/compassion for teens w. unwanted pregnancy	265

Question Number	Outcome (Abbreviated)	Effective Sample Size (N)
8p	Comfort - health/lifestyle impact of AIDS	272
8q	Comfort - long-term impact of teen pregnancy	268
8r	Comfort - gender orientation issues	262
9	HIV curriculum training (past two years)	273
9a	Type of HIV curriculum training received	56
9b	Who provided HIV curriculum training?	52
10	Basic facts areas - need training	189
11	Skill areas - need training	239
12	Attitudinal areas - need training	212
13	How far willing to travel for training?	252
14	Parental permission letters sent out prior to teaching about HIV/AIDS	261
15	Parents involved in HIV lessons	267
16	Information about HIV/AIDS provided parents	268
17	Responsible for teaching entire health curriculum	262
18	Professional background area	273
19	How long teaching HIV/AIDS?	271
20	Grade level teaching	273
21	How long do you spend on HIV?	264
22	HIV curriculum approved by local school board	269
23	Sources used to determine health needs	256
24	Percent of students opt out of class on HIV	262
25	Emphasis divided between information and skills	267